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	15G700	A. BUILDING 00 B. WING	02/25/2013

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ARC OF NORTHWEST INDIANA INC, THE	7318 ARKANSAS AVE HAMMOND, IN 46323

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W000000	This visit was for an annual recertification and state licensure survey. Dates of survey: February 5, 6, 7 and 25, 2013. Facility number: 003148 Provider number: 15G700 AIM number: 200360500 Surveyor Team: Christine Colon, Medical Surveyor III/QMRP-Team Leader Paula Chika, Medical Surveyor III/QMRP Paul Rowe, Federal Surveyor The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed March 8, 2013 by Dotty Walton, Medical Surveyor III.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, for 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed/implemented policy and procedures in regards to assuring quarterly pharmacist reviews were conducted and reviewed by the physician. Findings include: Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's December 2012 physician's orders indicated client #1 received routine medications which consisted of Ferrex (iron supplement), Losartan-Hydrochlorthiazide (blood pressure) and Sertraline HCL (hydrochloride) (behavior). Client #1's record indicated no quarterly pharmacy reviews had been conducted in regard to the client's medications for the 2012 calendar year. A review of client #2's record was conducted on 2/6/13 at 12:23 P.M. Client #2's most current physician's order dated 2/13 indicated she received routine	W000104	Pharmacy reviews will be addressed within 30 days of receiving them. To ensure future compliance, Nursing Manager will review Pharmacy reviews within 30days of receiving them and thereafter.	03/27/2013

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	medications which consisted of Thiothixene (Bipolar), Travatan (eye drop), Acetaminophen (pain), Maalox (indigestion), Pseudoephedrine (nasal congestion), Robafen (cough) and Imodium (diarrhea). Review of the record did not indicate quarterly pharmacy reviews had been conducted in regard to the client's medications for the 2012 calendar year. On 2/6/13 a record review was initiated for Client #3. Her physician's order, dated 1/6/13, documented she was prescribed medications including Loratadine, Medroxyprogesterone, Metoprolol, Nabumetone, Potassium, Saphris, Tizanidine, and Pseudoephedrine. The record did not include a quarterly drug regimen review completed by the pharmacist for the 2012 calendar year. A review of client #4's record was conducted on 2/6/13 at 4:00 P.M. Review of client #4's most current physician's order dated 2/13 indicated she received routine medications which consisted of Divalproex (bipolar), Fluticasone (nasal spray), Lyrica (seizures), Folic acid (anemia), Oxcarbazepine (seizures), Acetaminophen (pain), Maalox (indigestion) and Pseudoephedrine (nasal congestion). Review of client #4's record			

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	did not indicate quarterly pharmacy reviews had been conducted in regard to the client's medications for the 2012 calendar year. On 2/6/13 at 11:50 a.m. an interview was initiated with the Director of Nursing. She reported the agency did not have evidence of the required quarterly pharmacy reviews for the residents of the facility. She indicated the agency had experienced failures in obtaining quarterly pharmacy review reports and failures in nursing staff follow up to assure the reports were received and reviewed by the physician. 9-3-1(a)			

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W000111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. Based on interview and record review for 1 of 2 sampled clients (client #2) and 1 additional client (client #3), the facility failed to ensure all pertinent information in regard to each client's health was part of the client's chart/records. Findings include: A review of client #2's record was conducted on 2/6/13 at 12:23 P.M. A review of her Physician's order dated 1/28/13, indicated she was prescribed Thiothixene as a treatment for bipolar disease. No evidence existed in the record to document ongoing screening for extrapyramidal side effects of the use of Thiothixene. On 2/6/13 at 4:00 P.M., the Service Coordinator (SC) provided the surveyor with a document which she identified as a screening document for side effects of psychoactive medication that was given to her by the nurse to provide to the surveyor. The document was labeled, "Braden Scale for Predicting Pressure Sore Risk" and included a scoring system	W000111	Screenings for extra pyramidal are done during nursing quarterly physical assessment and most Psychiatric appointments.To ensure future compliance, Service Coordinator will audit Master files bi-annually and thereafter and attend psychiatric appointments.	03/27/2013

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	to evaluate skin integrity issues. No evidence of screening for extrapyramidal side effect of psychoactive medication was provided. A review of client #3's record was conducted on 2/6/13. Her physician's order dated 1/6/13, documented she was prescribed Saphris as a treatment for bipolar disorder. No evidence existed in the record to document ongoing screening for extrapyramidal side effects of the use of Saphris. On 2/6/13 at 1:15 P.M. an interview was initiated with Staff #7, the Licensed Practical Nurse, assigned to monitor the health of the people in the facility. She verified the absence of ongoing screening for extrapyramidal side effects of psychoactive medication for Client #3. She said the psychiatrist screened patients for extrapyramidal side effects of psychoactive medications at annual and semi-annual appointments. She said the psychiatrist used the AIMS (Abnormal Involuntary Movement Scale) to conduct the screenings. She verified the screening documents were not in the client records, adding the documents were on her desk. 9-3-1(a)			

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W000130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview, facility failed to ensure the privacy of clients in regard to dressing for 1 additional client residing at the group home (client #3). Findings include: During the 2/5/13 observation period between 5:45 AM and 8:40 AM, at the group home, client #3 sat on the floor in her underwear and nude from the waist up. Staff #9, who walked down the hallway and glanced into client #3's bedroom, did not close and/or redirect client #3 to close her bedroom door to protect the client's privacy. Interview with the Service Coordinator on 2/7/13 at 9:40 AM indicated facility staff should close and/or encourage the clients to close their bedroom doors when dressing. 9-3-2(a)	W000130	Service Coordinator will implement a formal training objective for client #3 to close doors when dressing/undressing. This training will be done through demonstration. Staff will also be trained on assisting clients in maintaining their privacy. To ensure future compliance, Service Coordinator will monitor twice monthly thereafter.	03/27/2013

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W000136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on interview and record review the facility failed to provide opportunities for out of home social and group activities for 2 of 2 sampled clients (clients #1 and #2) and for 2 additional clients (clients #3 and #4). Findings include: Interview with client #3 on 2/5/13 at 7:42 AM indicated she had not been shopping in the community recently. When asked if client #3 would like to go shopping, client #3 nodded her head, yes. Client #1's record was reviewed 2/6/13 at 12:57 PM. Client #1's Residential Services daily logs from 11/1/12 to 1/31/13 indicated client #1 had not participated in community activities and/or outings as there were no documented community activities/outings to review for the calendar year of 2012. A review of client #2's record was conducted on 2/6/13 at 12:23 PM. Client #2's record did not indicate the client had participated in any community activities	W000136	3/27/13The Service Coordinator will train group home staff to plan and document all outings on a calendar and to plan and complete weekend plans to be sent in weekly. To ensure future compliance, Service Coordinator will review weekly for three months and monthly thereafter with additional training if needed.	03/27/2013

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	and/or outings as there were no documented outings/activities to review for the calendar year of 2012. On 2/6/13 a record review was initiated for Client #3. No evidence existed in her record of social, shopping or community integrating activities documented by the facility. A review of client #4's record was conducted on 2/6/13 at 1:00 P.M.. Client #4's record did not indicate the client had participated in any community activities and/or outings as there were no documented outings/activities to review for the calendar year of 2012. Interview with staff #8 on 2/5/13 at 6:22 PM stated clients #1, #2, #3 and #4 used to go into the community "all the time." Staff #8 stated "Not as much in winter time." When asked where community outings/activities were documented, staff #8 stated "On logs." On 2/6/13 at 3:30 p.m. an interview was initiated with the Qualified Mental Retardation Professional (referred to by the facility as the Service Coordinator). She reported the agency had a system in place to provide and document community integrating activities provided but verified the absence of documentation			

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	of such activities provided for clients #1, #2, #3 and #4 who resided at the facility. 9-3-2(a)			

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W000137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation and interview, the facility failed to provide age appropriate activities while at the facility owned day program, for 1 of 2 sampled clients (client #2). Findings include: A facility owned day program observation was conducted on 2/5/13 from 11:10 A.M. until 1:25 P.M. At 11:30 A.M., Direct Support Professional (DSP) #8 handed client #2 a large wooden children's puzzle and prompted her to play with the puzzle. Client #2 was not provided any other activities during the observation. An interview with the Service Coordinator (SC) was conducted on 2/6/13 at 3:30 P.M. The SC indicated client #2 should be offered age appropriate activities. 9-3-2(a)	W000137	The Developmental Specialist has trained staff over active treatment. Staff will work with clients at 5 minute intervals throughout the day with age appropriate materials. Developmental Specialist has removed all inappropriate materials from the rooms. To ensure future compliance, Service Coordinator will monitor bi-weekly and thereafter. Developmental Specialist will monitor on a daily basis with continuous training as needed.	03/27/2013

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W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 clients residing at the home (clients #1, #2, #3 and #4), the facility's Qualified Mental Retardation Professional (QMRP) did not integrate social activities, did not coordinate staff training or monitor programs for clients at the facility's day program, did not integrate communication training in Individual Support Plans (ISPs), and the QMRP failed to monitor clients' programs to ensure they contained program methodologies, criteria for attainment, were revised as needed, and were implemented. Findings include: 1. Please refer to W136. The QMRP failed to provide opportunities for out of home social and group activities for 4 of 4 clients (Client #1, #2, #3 and #4). 2. Please refer to W137 for the QMRP's failure to monitor the facility's day program to ensure age appropriate activities were provided, for 1 of 2 sampled clients (client #2).	W000159	The Developmental specialist has trained staff over active treatment. Staff will work with clients at 5 minute intervals throughout the day with age appropriate materials. Developmental Specialist has removed all inappropriate materials from the rooms. To ensure future compliance, Service Coordinator will monitor bi-weekly and thereafter. Developmental Specialist will monitor on a daily basis. See # 136,137,189,227,231,249,240, and 257	03/27/2013

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	3. Please refer to W189. The QMRP failed to provide initial and continuing training to assure staff competence in the use of latex gloves intended to prevent cross contamination. This failure had the potential to affect all clients living in the facility (#1, #2, #3, and #4). 4. The QMRP failed to address the clients' identified training needs in regard to privacy and communication for clients #1 and #2. Please see W227. 5. The QMRP failed to ensure client #1's Individual Support Plan (ISP) objectives included specific criteria for completion. Please see W231. 6. The QMRP failed for 1 of 2 sampled clients (#1), to ensure methods were included in client #1's Individual Support Plan (ISP) to ensure facility staff knew how to monitor/supervise the client at the day program to prevent the client from getting into the trash, from taking others' lunches and/or searching for food. The QMRP failed to ensure the client's ISP indicated how facility staff were to get client #1 to attend scheduled doctor's appointments. Please see W240. 7. The QMRP failed to ensure facility staff implemented clients (#1 and #2's) program plans/objectives when formal			

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	and/or informal training opportunities existed. Please see W249. 8. The QMRP failed to revise clients' objectives after no progress had been made for client #1. Please see W257. 9-3-3(a)			

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W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, interview and record review the facility failed to provide sufficient direct care staff to manage and supervise 3 of 3 clients attending the workshop (Clients #1, #3 and #4). Findings include: On 2/5/12 between 11:20 a.m. and 1:30 p.m. observations were conducted in the facility owned workshop attended by clients #1, #3, and #4. Some people (clients) were engaged in coloring, others in talking, and some others were sitting at tables looking down or around the room. Forty clients and five staff members were present. Two of the staff members were engaged in checking and filling boxes with eyeglasses' cleaning cloths encased in plastic sleeves. One of the staff members (Staff #3) sat at a desk talking on the telephone and reviewing papers while making marks on some of the sheets of paper. The remaining two staff members interacted with some of the	W000186	Work shop manager has rearranged staff lunch schedules (10:1) at all times of the day in the pre-voc area. 3/27/13 So that a ratio of (10:1) is maintained. To ensure future compliance, workshop manager will monitor on a daily basis and rearrange schedules as needed.	03/27/2013

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	clients as they sat at tables. There were five staff members in the room, only two were engaged in providing direct supports to the 40 clients present. At 11:25 a.m. there were 40 clients present and 3 staff members (ratio of 1 staff to 13 clients), at 11:30 a.m. there were 42 clients and 3 staff members (ration of 1 to 14), and at 11:45 a.m. there were 39 clients and 3 staff (ratio of 1 to 13 clients). At 11:33 a.m. staff and clients left the workshop for the lunch room, leaving 1 staff in the workshop with 28 clients (ratio of 1 to 28). The staff member remaining behind (Staff #3) had a telephone cradled between her ear and her shoulder and was engaged in a telephone conversation. Staff #3 looked at individual pages from a stack of papers on the desk in front of her as she carried on a telephone conversation. She did not notice as Client #1 rose from a table where she sat and walked to a trash can located near a staff member's desk in the room. Client #1 leaned over the trash can and rummaged through it. She removed a discarded tissue which she used to wipe her nose and clean inside her nostrils. Staff #3 did not see this incident as she continued to speak on the phone and attend to the papers on her desk. At 12:50 p.m. there were 3 staff and 37 clients (ratio of 1 staff to 11 clients).			

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	At 12:55 p.m. there were 3 staff and 39 clients (ratio of 1 staff to 13 clients). At 1:05 p.m. there were 3 staff and 38 clients (ratio of 1 staff to 12 clients). At 1:10 p.m. there were 1 staff and 38 clients (ratio of 1 staff to 19 clients). On 2/5/13 at 1:15 p.m. an interview was initiated with Staff #3. She identified herself as the Workshop Manager. She said the staffing ratio at the workshop was established as 1 staff member to every 10 clients. She explained the number of staff and clients in the room varies as people move in and out of the workshop room. She verified not seeing Client #1 rummaging through the trash can, removing a discarded tissue and wiping her nose/cleaning her nostrils with it. She verified there were too few staff present in the room to be able to effectively monitor and prevent Client #1 from taking items from the trash cans. 9-3-3(a)			

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W000189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, interview and record review the facility failed to provide initial and continuing training to assure staff competence in the use of latex gloves intended to prevent cross contamination. This failure had the potential to affect all clients attending the workshop (clients #1, #3 and #4). Findings include: On 2/5/12 between 11:20 a.m. and 1:30 p.m. observations were conducted in the facility owned workshop. On 2/5/13 at 12:15 p.m. an observation was initiated in the lunch room at the facility owned workshop. Client #3 sat at a dining table eating her lunch. During the meal, drool spilled from her mouth onto the table. Staff #2 (Direct Support Professional) approached the table and wiped up the drool spill with a rag. She wore latex gloves on each hand. Three clients (not in the sample) sat at the adjacent table and one of them spilled food from his plate onto the table between them. Staff #2 moved to that table and wiped up the spilled food with the same rag and same	W000189	The health and Safety Tech has retrained all staff on infection control, cross contamination, and the use of gloves.Gloves will be available at Health and Safety Techs office, in the cafeteria, and the kitchen area during lunch time for staff to use as needed. To ensure future compliance, Health and Safety Tech will monitor on a daily basis and train staff as needed. New staff will be trained before they start working.	03/27/2013

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	gloves. Staff #2 then moved to the pass through counter between the dining room and the kitchen where she leaned with her back to the counter as she watched the activity in the dining room. As she stood watching, she placed her gloved hands on the counter top and closed her fingers against the underside of the counter top. She continued to move from client to client, assisting with meal time supports without changing her gloves. At 12:15 p.m. as Client #1 approached Staff #2, Staff #2 raised her right hand (still gloved) to give Client #1 a "high five" onto Client #1's bare hand. On 2/5/13 at 12:30 p.m. an interview was initiated with Staff #2. She reported she wore gloves to, "Keep her hands clean." She indicated the gloves were worn for sanitation. When the observations of failure on her part to change the gloves before coming into contact with different clients and the "high five" given with contaminated gloves, she responded, "You are right, I didn't change them, but I should have." Asked if she received training on the use of latex gloves, she said she had been trained sometime in the past, but was not sure when she received that training. On 2/5/13 at 1:00 p.m. an interview was initiated with Staff #5, the Health and			

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	Safety Tech. for the workshop. She reported she served as the trainer for the facility on all health/safety related topics. She said she trained the staff annually on Universal Precautions. She said it had been about 12 months since the previous training. She indicated that she discussed the purpose and use of latex gloves in her Universal Precautions training. Staff #5 said she had little opportunity to do continuing observation and training on the staff's use of latex gloves during the mealtime, due to her other duties including passing medications at midday. On 2/7/13 the facility provided records of the subject matter for the Universal Precautions training. These training documents included no written information about the appropriate use of latex gloves. The training materials included a picture of woman holding her hand up, wearing a latex glove on her hand. 9-3-3(a)			

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W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review, the clients' interdisciplinary teams (IDTs) failed to address the clients' identified training needs in regard to privacy and communication for 2 of 2 sampled clients (clients #1 and #2). Findings include: During the 2/5/13 observation period between 5:45 AM and 9:40 AM, at the group home, client #2 dressed with her bedroom door open. Client #2 removed her pajama top and bottom and put on her underwear, bra and clothing for the day with the door open as the client stood near the door way to the bedroom. No staff witnessed and/or saw client #2 get dressed for the day. During the entire observation period; client #2 did not, and was not prompted to, communicate in her home. During the 2/5/13 observation period, client #1 walked back and forth from the bathroom to the bedroom nude/without any clothing multiple times from 6:29 AM to 7:43 AM.	W000227	The Service Coordinator will implement a formal training goal on privacy for clients # 1 & 2 To ensure future compliance, Service Coordinator will monitor bi-weekly for one month and monthly thereafter. 3/27/13 The Service Coordinator will implement a formal training objective on privacy for clients #1 & 2 and train staff at the group home on running this objective. The training will be done through demonstration. Staff will also be trained on assisting clients' in maintaning their privacy.	03/27/2013

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	Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's 8/15/12 Individual Support Plan (ISP) indicated client #1 did not receive formal training in regard to privacy. Client #2's record was reviewed on 2/6/13 at 12:23 PM. Client #2's 8/23/12 ISP did not indicate client #2 received formal training in regard to privacy and communication. Interview with staff #8 on 2/5/13 at 6:23 PM indicated client #2 would dress with the door open. Staff #2 stated "We train her but she has to be redirected often." Staff #8 stated client #1 would "normally put on a robe" when going to and from the bathroom. Staff #8 indicated client #1 would go back and forth to her bedroom and the bathroom. Interview with the Service Coordinator (SC) on 2/7/13 at 9:40 AM indicated she was not aware client #1 would walk nude from the bathroom to her bedroom. The SC indicated client #1 and #2's ISPs did not address the clients' identified training needs in regard to privacy. The SC further indicated client #2 did not have a communication training objective. 9-3-4(a)			

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W000231	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. Based on interview and record review, the client's Individual Support Plan (ISP) objectives did not specifically include a criteria for completion for client #1. Findings include: Client #1's 8/15/12 ISP indicated client #1 had the following objectives: -"[Client #1] will use communication book to identify needs for 10 of the last 10 sessions by August 31, 2013." -"[Client #1] will identify items that can be purchased with money available for 10 of the last 10 sessions by August 31, 2013." -"[Client #1] will set her place at the dinner table for 10 of the last 10 sessions by August 31, 2013." -"[Client #1] will write or recite her telephone number and address from memory for 10 of the last 10 sessions by August 31, 2013." "[Client #1] will identify the five rights of	W000231	The IDT team will review client # 1 objectives and add criteria for completion and change or modify as necessary. To ensure future compliance, service Coordinator will review monthly and thereafter. In addition, all objectives will be modified or changed as needed or at least during the annual meeting, and staff will be trained as needed.	03/27/2013

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	one medication for 10 of the last 10 sessions by August 31, 2013." Client #1's above mentioned objectives did not include a specific criteria (prompt levels) of completion to determine when the client's objectives would be considered achieved. Interview with Service Coordinator (SC) on 2/7/13 at 9:40 AM indicated client #1's objectives did not include a percentage/criteria of completion which would determine when the client's objectives were achieved/met. 9-3-4(a)			

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W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review, for 1 of 2 sampled clients (#1), the client's Individual Support Plan (ISP) did not indicate how facility staff were to monitor/supervise the client at the day program to prevent the client from getting into the trash, from taking others' lunches and/or searching out food. The client's ISP also did not indicate how facility staff were to get client #1 to attend scheduled doctor's appointments. Findings include: 1. An observation was conducted at the facility owned day program on 2/5/13 between 11:16 AM and 1: 50 PM. At 11:50 AM, client #1 walked into the dining room and went to the table where client #3 was sitting. Client #3 gave client #1 a peanut butter cracker and client #1 placed the cracker into her mouth. Client #1 looked around the dining room at the other clients who were already eating. At 12:05 PM, client #1 was heating her food up in the microwave at the front of the cafeteria. Client #1 walked by an unidentified female client sitting in a wheelchair eating who dropped some food onto the floor. Client	W000240	An interm meeting will be held to address client#1 ISP and will add an addendum to include instructions on how staff at day services will supervise and monitor the client to prevent client from getting into the trash and from taking others lunches. Instructions to get client #1 to her scheduled Dr. appointments will be included and Behavior Support Plan will be revised. Service Coordinator will monitor client once per week for one month and bi-weekly thereafter during lunch Service Coordinator will monitor client as needed for Dr. appointments. Workshop manager retrained al pre-voc staff on continuously monitoring all clients during lunch time to ensure clients are not going through garbage, taking others food or eating food off the floor. Staff were trained on redirecting clients if these issues occur. To ensure future compliance workshop manager and all DSPs on lunch will monitor on a daily basis	03/27/2013

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	#1 walked by the client, bent over, picked the food up off the floor and placed it into her mouth. Client #1 walked back over to the microwave and started looking around the dining room for food. At 12:19 PM, client #1 finished eating and carried her wrappers and paper up to the garbage to dispose. On the way back to her table, client #1 reached over to an unidentified male client's food and attempted to take the client's food. The unidentified client yelled "No" and pulled his food toward him to keep client #1 from taking it. Staff #2 and #4 were in the dining room, staff #2 and staff #4 did not directly monitor/supervise and/or redirect client #1's behavior. Client #1 went to the staff's lounge located off the dining room and attempted to search for food in the lockers in the staff's lounge area. At 12:40 PM, it was announced it was time to go back to the prevocational area. Client #1 remained back in the dining room area for a couple of minutes before walking back to the workshop area. Before leaving, client #1 had a cookie in her mouth which did not belong to her. Once in the workshop area, client #1 left the workshop area and went back to the staff lounge area located off the dining room. Staff in the workshop did not follow client #1 when she left the workshop area. Client #1 was looking for food in the staff lounge area. Client #1			

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	was redirected to return to her program area by another workshop office staff. Client #1 went to the bathroom before returning to the workshop area. At 12:50 PM, client #1 left the workshop area again and returned without staff monitoring and/or supervision. At 1:12 PM, client #1 walked from her work area to the front of the workshop and started going through the trash. There were 4 staff in the workshop area at that time, and the workshop staff did not redirect the client from going through the trash. Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's 8/12 Positive Behavioral Support Plan (PBSP) indicated "...In reviewing [client #1's] reported behaviors over the past 2 years, nearly 40% of the incidents can be traced back to her attempts to obtain food from her peers or the cafeteria. [Client #1's] desire for sensory stimuli also includes food. However, [client #1] does not understand the social norms regarding food and its consumption. She does not appear to understand sanitary issues or palatability of some items. She may take food from the garbage...." Client #1's PBSP indicated "...While observing [client #1] allows (sic) ample personal space, she does not like to be followed, so only do so from a safe distance...." Client #1's PBSP in regard to digging in the			

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	garbage indicated, "After food items are disposed of in the trash, especially if these items are unhealthy to eat (raw meats, spoiled food) the garbage bag should be tied shut and removed to an outside receptacle-one that [client #1] has less access to." Client #1's 8/12 PBSP did not indicate how facility staff were to monitor/supervise client #1, at the day program, to prevent the client from searching/seeking out food, taking food from others in the lunch room, and/or to keep the client from digging through trash/garbage. Interview with staff #2 on 2/5/13 at 12:40 PM indicated client #1's behavior had improved at the day program. Staff #2 stated "We have to keep a close eye on her." Interview with the Service Coordinator (SC) on 2/7/13 at 9:40 AM indicated client #1 required supervision and monitoring at the workshop to prevent the client from taking food and/or digging in the trash/garbage. The SC indicated client #1's PBSP used to indicate how facility staff were to monitor the client. The SC indicated the supervision/monitoring would need to be placed back into the client's PBSP. 2. Client #1's record was reviewed on			

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ARC OF NORTHWEST INDIANA INC, THE	7318 ARKANSAS AVE HAMMOND, IN 46323

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	2/6/13 at 12:57 PM. Client #1's Medical Record indicated the following: -1/30/12"[Client #1] had a dental appt (appointment) today. Refused. It will be rescheduled." -5/11/12 "[Client #1] refused her mammogram appointment today. It will be re-scheduled." -6/8/12 "[Client #1] refused her Mammo (mammogram) today. Will be rescheduled." -6/22/12 "PT (patient) REFUSED TO COOPERATE FOR MAMMOGRAM. UNABLE TO DO TEST DUE TO PT'S COOPERATION." -7/3/12 "Refused mammo today. Consulted with Service Coordinator. Rescheduled for 7-16-12 at 2:00 p.m." -"[Client #1] refused her eye exam unable to reschedule due to [client #1] fighting at Dr. (doctor) and her staff." -12/4/12 "Consumer (client #1) refused to be x-rayed." -1/2/13 "[Client #1] refused to go on her cxr (chest x-ray) appt."			

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	-1/25/13 "[Client #1] refused her annual Px (physical examination)." Client #1's 11/29/11 doctor's prescription indicated client #1 required a chest xray due to having a positive PPD (mantoux test). Client #1's 8/15/12 Individual Support Plan (ISP) indicated client #1 had an objective to "...respond appropriately with 80% independence for 10 of the last 10 sessions by August 31, 2013." Client #1's methodology indicated "Three times per week staff will discuss with [client #1] the importance of attending doctor's appointments. Staff will ask questions such as 'Why is important to go to the doctor?(sic)' ...'Who takes you to the appointment?'...Staff will explain what a regular doctor visit is like, what a neurologist appointment is like, what getting a blood test is like, and what a cardiologist appointment is like...." Client #1's 8/15/12 ISP objective and/or 8/12 PBSP did not specifically indicate how and/or what facility staff were to do to assist client #1 to attend her doctor's appointment on the scheduled day. Interview with the Service Coordinator (SC) on 2/7/13 at 9:40 AM indicated client #1 refused to attend doctors' appointments. The SC indicated client			

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	#1's ISP and/or PBSP did not indicate how staff were to assist the client to attend scheduled appointments when they came up. The SC indicated the SC was going to try and take client #1 to her rescheduled physical examination appointment at the end of February and if that did not work, the client's mother would take the client to the doctor. 9-3-4(a)			

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W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, the facility failed to implement written objectives during times of opportunity for 2 of 2 sampled clients (clients #1 and #2.) Findings include: A morning observation was conducted at the group home on 2/5/13 between 5:45 AM and 8:40 AM. At the group home, client #1, who had limited communication skills, was not encouraged to utilize any communication devices and/or books during the observation period. Client #1 spent the majority of her time going back and forth to the bathroom from her bedroom and/or stayed in the bathroom. Facility staff #9 and #10 did not redirect the client to finish in the bathroom and/or to set her own place setting at the table for breakfast. Once client #1 was finished bathing and dressing for the day, facility staff did not prompt and/or encourage client #1 to clean the shower stall. During the entire observation period client #2 did	W000249	Group home staff will be trained on implementing active treatments activities To ensure future compliance, Service Coordinator will monitor weekly for one month and bi-weekly thereafter. Workshop manager retrained Pre-Voc staff on running goals/objectives whether formal or informal at all times of opportunity. Work shop manager has also trained all Pre-Voc staff on keeping clients focused on production or other programming activities. To ensure future compliance, workshop manager will monitor on a daily basis, and Service Coordinator will monitor on a monthly basis.	03/27/2013

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	not communicate in her home. Facility staff #9 and #10 would check on client #2 but did not prompt her to any meaningful activity. A facility owned day program observation was conducted on 2/5/13 from 11:15 A.M. until 1:50 P.M. From 11:15 A.M. until 12:00 P.M., client #2 sat at a table with a wooden children's puzzle sitting in front of her. Client #2 sat with no activity and was not prompted to any activity. At 11:50 AM, client #1 walked into the dining room and went to the table where client #3 was sitting. Client #3 gave client #1 a peanut butter cracker and client #1 placed the cracker into her mouth. Client #1 looked around the dining room at the other clients who were already eating. At 12:05 PM, client #1 was heating her food up in the microwave at the front of the cafeteria. Client #1 walked by an unidentified female client sitting in a wheelchair eating who dropped some food onto the floor. Client #1 walked by the client, bent over, picked the food up off the floor and placed it into her mouth. Client #1 walked back over to the microwave and started looking around the dining room for food. At 12:19 PM, client #1 finished eating and carried her wrappers and paper up to the garbage to dispose. On the way back to her table, client #1 reached over to an unidentified			

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	male client's food and attempted to take the client's food. At 12:45 P.M., client #1 walked out of the workshop area down the hall and went into the staff's lunch room. Client #1 dug into the garbage can and grabbed something out of it and put it in her mouth and ate it. At 1:15 P.M., client #1 walked out of the workshop area to the front office area and dug into a garbage can, grabbed an empty candy bar paper, smelled it and put it back into the trash can. During the 2/5/13 observation period between 4:55 PM and 6:50 PM, at the group home, client #1 independently cleaned the bathroom and mopped the floor without training, prompts and/or redirection from staff. Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's 8/15/12 Individual Support Plan (ISP) indicated client #1 had objectives to use her communication book, to clean the bathroom shower stall, and an objective to set her place at the dining room table. Facility staff #8 and #9 did not implement client #1's above mentioned objectives when formal and/or informal training opportunities existed. Client #1's 8/12 Positive Behavioral Support Plan (PBSP) indicated "...Once			

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	[client #1] has finished eating she should be encouraged to become involved in another activity possible visiting with peers or staff members for which she is fond (sic). She may enjoy being part of the cleaning crew, or she may enjoy listening to music or looking at pictures. Regardless she should be redirected to do something else rather than be allowed to focus on what others are eating or doing with food...." A review of client #2's record was conducted on 2/6/13 at 12:23 P.M. Client #2's ISP dated 8/23/12 indicated the following training objectives: "Will participate in a group activity...Will learn to identify coins, penny, nickel, dime, quarter...Will increase participation in fitness activity." Interview with the Service Coordinator (SC) on 2/7/13 at 9:40 AM indicated client #1 had an objective to use her communication book when needed and an objective to clean the bathroom shower stall. The SC indicated facility staff should have assisted and/or taught the client to clean the shower stall as the client was able to clean other parts of the bathroom independently. The SC indicated client #1's PBSP, to redirect client #1 to another activity after the client finished eating, was not being			

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	implemented at the facility's owned day program/workshop. The SC further indicated staff should implement clients' training objectives "at all times of opportunity." 9-3-4(a)			

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W000257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed for 1 of 2 sampled clients (client #1), to revise the client's objectives after no progress had been made. Findings include: 1. Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's Medical Record indicated the following: -1/30/12"[Client #1] had a dental appt (appointment) today. Refused. It will be rescheduled." -5/11/12 "[Client #1] refused her mammogram appt today. It will be re-scheduled." -6/8/12 "[Client #1] refused her Mammo (mammogram) today. Will be rescheduled." -6/22/12 "PT (patient) REFUSED TO COOPERATE FOR MAMMOGRAM.	W000257	Client # 1 objective will be reviewed and revised by The IDT team. To ensure future compliance, Service Coordinator will review monthly and thereafter. In addition, all objectives will be modified or changed as needed or at least at the annual meetings.	03/27/2013

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	UNABLE TO DO TEST DUE TO PT'S COOPERATION." -7/3/12 "Refused mammo today. Consulted with Service Coordinator. Rescheduled for 7-16-12 at 2:00 p.m." -"[Client #1] refused her eye exam unable to reschedule due to [client #1] fighting at Dr. (doctor) and her staff." -12/4/12 "Consumer refused to be x-rayed." -1/2/13 "[Client #1] refused to go on her cxr (chest x-ray) appt." -1/25/13 "[Client #1] refused her annual Px (physical examination)." Client #1's 11/29/11 doctor's prescription indicated client #1 required a chest X-ray due to having a positive PPD (Mantoux test). Client #1's 8/15/12 Individual Support Plan (ISP) indicated client #1 had an objective to "...respond appropriately with 80% independence for 10 of the last 10 sessions by August 31, 2013. Client #1's Progress Notes Summary (monthly summaries) indicated the following: December 2012 - 38 to 41.4%			

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	November 2012 - 37.5% to 42% October 2012 - no data September 2012 - 51.9% Client #1's 8/15/12 ISP did not indicate the QMRP had revised the client's objective due to lack of progress. Interview with the Service Coordinator (SC-QMRP) on 2/7/13 at 9:40 AM indicated client #1 refused to attend doctor appointments. The SC indicated client #1's 8/15/12 ISP objectives had not been revised. 9-3-4(a)			

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W000315	483.450(e)(4)(i) DRUG USAGE Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff. Based on record review and interview, the facility failed to provide evidence of preventive screening for extrapyramidal side effects of psychoactive medications for 1 of 2 sampled clients (client #2) and 1 additional client (client #3) who received psychotropic medications. Findings include: A review of client #2's record was conducted on 2/6/13 at 12:23 P.M.. A review of her Physician's order dated 1/28/13, indicated she was prescribed Thiothixene as a treatment for bipolar disease. No evidence existed in the record to document ongoing screening for extrapyramidal side effects of the use of Thiothixene. On 2/6/13 at 4:00 P.M., the SC provided the surveyor with a document which she identified as a screening document for side effects of psychoactive medication that was given to her by the nurse to provide to the surveyor. The document was labeled, "Braden Scale for Predicting Pressure Sore Risk" and included a scoring system to evaluate skin integrity	W000315	See # 111	03/27/2013

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	issues. No evidence of screening for extrapyramidal side effect of psychoactive medication was provided. A review of client #3's record was conducted on 2/6/13. Her physician's order dated 1/6/13, documented she was prescribed Saphris as a treatment for bipolar disorder. No evidence existed in the record to document ongoing screening for extrapyramidal side effects of the use of Saphris. On 2/6/13 at 1:15 P.M. and interview was initiated with Staff #7, the Licensed Practical Nurse assigned to monitor the health of the people in the facility. She verified the absence of ongoing screening for extrapyramidal side effects of psychoactive medication for Client #3. She said the psychiatrist screened patients for extrapyramidal side effects of psychoactive medications at annual and semi-annual appointments. She said the psychiatrist used the AIMS (Abnormal Involuntary Movement Scale) to conduct the screenings. She verified the screening documents were not in the client records, adding the documents were on her desk. 9-3-5(a)			

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W000322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview the facility failed to provide evidence of a current annual physical for 1 of 2 sampled clients (client #1). Findings include: Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's record indicated client #1 did not have a current physical examination in her record as the last one was dated 12/14/11. Client #1's 12/12 signed physician's orders indicated client #1 received routine medications (Zoloft-behavior, Ferrex-iron deficiency, Losartan-HCTZ-blood pressure). Client #1's 12/12 orders indicated the client was allergic to bees and an Epi pen injector (allergic reaction) was used as needed. Interview with the Service Coordinator (SC) on 2/7/13 at 9:40 AM indicated client #1 did not have a current physical examination. The SC indicated client #1 was to go to the doctor at the end of the month (2/13). 9-3-6(a)	W000322	Client # 1 physical is scheduled for 4/8/13 To ensure future compliance, Service Coordinator will add an addendum to clients Behavior Plan to include instructions for getting client #1 to her scheduled appointments.Service Coordinator will monitor all scheduled appointments for compliance, and attend appointments if necessary.	03/27/2013

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W000362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview the agency nursing staff failed to assure quarterly pharmacy reviews were obtained and reviewed by the physician affecting 4 of 4 clients who lived in the facility (clients #1, #2, #3 and #4). Findings include: Client #1's record was reviewed on 2/6/13 at 12:57 PM. Client #1's December 2012 physician's orders indicated client #1 received routine medications which consisted of Ferrex (iron supplement), Losartan-Hydrochlorthiazide (blood pressure) and Sertraline HCL (behavior). Client #1's record indicated no quarterly pharmacy reviews had been conducted in regard to the client's medications for the calendar year of 2012. A review of client #2's record was conducted on 2/6/13 at 12:23 P.M.. Client #2's most current physician's order dated 2/13 indicated she received routine medications which consisted of Thiothixene (Bipolar), Travatan (eye drop), Acetaminophen (pain), Maalox (indigestion), Pseudoephedrine (nasal congestion), Robafen (cough) and	W000362	See # 104	03/27/2013

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	Imodium (diarrhea). Review of the record did not indicate quarterly pharmacy reviews had been conducted in regard to the client's medications for the calendar year of 2012. On 2/6/13 a record review was initiated for Client #3. Her physician's order, dated 1/6/13, documented she was prescribed medications including Loratadine, Medroxyprogesterone, Metoprolol, Nabumetone, Potassium, Saphris, Tizanidine, and Pseudoephedrine. The record did not include a quarterly drug regimen review completed by the pharmacist for the calendar year of 2012. A review of client #4's record was conducted on 2/6/13 at 4:00 P.M.. Review of client #4's most current physician's order dated 2/13 indicated she received routine medications which consisted of Divalproex (bipolar), Fluticasone (nasal spray), Lyrica (seizures), Folic acid (anemia), Oxcarbazepine (seizures), Acetaminophen (pain), Maalox (indigestion) and Pseudoephedrine (nasal congestion). Review of client #4's record did not indicate quarterly pharmacy reviews had been conducted in regard to the client's medications for the calendar year of 2012.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 2/6/13 at 11:50 a.m. an interview was initiated with the Director of Nursing. She reported the agency did not have evidence of the required quarterly pharmacy reviews for the residents of the facility. She explained that the agency had experienced failures in obtaining quarterly pharmacy review reports and failures in nursing staff follow up to assure the reports were received and reviewed by the physician. 9-3-6(a)			

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	15G700	A. BUILDING 00 B. WING	02/25/2013

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W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, interview and record review, the facility failed to ensure all medications were administered without error for 1 of 16 doses administered for client #2. Findings include: During the 2/5/13 observation period between 5:45 AM and 8:40 AM, at the group home, staff #9 administered Fluticasone Nasal Spray (allergies), 1 spray, in each nostril of client #2. Client #2's February 2013 Medication Administration Record (MAR) was reviewed on 2/5/13 at 8:14 AM. Client #2's February 2013 MAR indicated client #2 was to receive Fluticasone Nasal Spray 2 sprays in each nostril daily. Client #2's record was reviewed on 2/6/13 at 12:23 PM. Client #2's December 2012 physician's order indicated client #2 was to receive "Fluticasone Propos micrograms 2 sprays in each nostril once a day as directed." Interview with staff #9 on 2/5/13 at 8:20	W000369	Community Services Nurse will train DSP on administering Fluticasone nasel spray to client #2 as directed.To ensure future compliance, Community Services nurse or Service Coordinator will monitor weekly for 1 month and bi-monthly thereafter.	03/27/2013

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	AM indicated client #2's Fluticasone label and MAR indicated 2 sprays in each nostril. Staff #9 indicated she administered 1 spray in each nostril. Staff #2 indicated she thought the facility nurse had told her to administer 2 sprays in each nostril during the allergy season and 1 spray in each nostril during the winter months. Staff #9 stated "I may have got clients mixed up." 9-3-6(a)			

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W000440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills on the overnight staff shift (11:00 P.M. to 7:00 A.M.) during the second quarter (April 1st through June 30th) and no drills for the fourth quarter (October 1st through December 31st) of 2012 which affected 4 of 4 clients living in the facility (clients #1, #2, #3 and #4). Findings include: The facility's records were reviewed on 2/5/13 at 3:23 P.M. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3 and #4 on the overnight shift of staff during the second quarter of 2012. Further review indicated no drills were conducted for any staff shift during the fourth quarter of 2012. The Area Manager (AM) was interviewed on 2/5/13 at 3:40 P.M. The AM indicated evacuation drills are to be conducted during each quarter for each shift of personnel. The AM further indicated there should have been drills conducted April 1st through June 30th for the 11:00 P.M. to 7:00 A.M. shift and for October 1st through December 31st 2012 for the 7:00 A.M. to 3:00 P.M., 3:00 P.M. to 11:00	W000440	Group home staff will be re-trained by area manager on conducting fire drills every month, shift 7-3; 3-11; 11-7, and to document in fire drill folder. To ensure future compliance, staff will send in fire drill folder to Area Manager every Monday for review.	03/27/2013

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	P.M. and 11:00 P.M. to 7:00 A.M. shifts. 9-3-7(a)			

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W000455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review and interview, the facility failed to maintain proper hygiene practices and prevent cross contamination, during mealtime. This failure had the potential to affect all clients attending the workshop (clients #1, #3 and #4). Findings include: On 2/5/13 at 12:15 a.m. an observation was initiated in the lunch room at the facility owned workshop. Client #3 sat at a dining table eating her lunch. During the meal, drool spilled from her mouth onto the table. Staff #2 (Direct Support Professional) approached the table and wiped up the drool spill with a rag. She wore latex gloves on each hand. Three clients (not in the sample) sat at the adjacent table and one of them spilled food from his plate onto the table between them. Staff #2 moved to that table and wiped up the spilled food with the same rag and same gloves. Staff #2 then moved to the pass through counter between the dining room and the kitchen where she leaned with her back to the counter as she watched the activity in the dining room. As she stood watching, she	W000455	The Health and Safety Tech has re-trained all staff on infectin control, cross contamination, and the use of gloves.Gloves will be available at health and Safety Tech's office, in the cafeteria and the kitchen area during lunch time for staff to use as needed. To ensure future compliance, Health and Safety Tech will monitor on a daily basis and train staff as needed. New staff will be trained before they start working.	03/27/2013

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	placed her gloved hands on the counter top and closed her fingers against the underside of the counter top. She continued to move from client to client, assisting with meal time supports without changing her gloves. At 12:15 p.m. as Client #1 approached Staff #2, Staff #2 raised her right hand (still gloved) to give Client #1 a "high five" onto Client #1's bare hand. On 2/5/13 at 12:30 p.m. an interview was initiated with Staff #2. She reported she wore gloves to, "Keep her hands clean." She indicated that the gloves were worn for sanitation. When the observations of failure on her part to change the gloves before coming into contact with different clients and the " high five " given with contaminated gloves, she responded, "You are right, I didn't change them, but I should have." Asked if she received training on the use of latex gloves, she said she had been trained sometime in the past, but was not sure when she received that training. On 2/5/13 at 1:00 p.m. an interview was initiated with Staff #5, the Health and Safety Tech. for the workshop. She reported she served as the trainer for the facility on all health/safety related topics. She said she trained the staff annually on Universal Precautions. She said it had			

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	been about 12 months since the previous training. She indicated that she discussed the purpose and use of latex gloves in her Universal Precautions training. Staff #5 said she had little opportunity to do continuing observation and training on the staff's use of latex gloves during the mealtime, due to her other duties including passing medications at midday. On 2/7/13 the facility provided records of the subject matter for the Universal Precautions training. These training documents included no written information about the appropriate use of latex gloves. The training materials included a picture of woman holding her hand up, wearing a latex glove on her hand. 9-3-7(a)			

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W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview, the facility failed to assure 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4) assisted in meal preparation. Findings include: A morning observation was conducted at the group home on 2/5/13 from 5:45 A.M. until 8:45 A.M. At 6:19 A.M., Direct Support Professional (DSP) #9 boiled eggs and cooked sausage patties while client #2 sat with no activity. At 6:50 A.M., clients #1, #2, #3 and #4 ate independently. Clients #1, #2, #3 and #4 did not assist in meal preparation. An interview with the Service Coordinator (SC) was conducted on 2/6/13 at 10:20 A.M. The SC indicated clients were capable of assisting in meal preparation and further indicated they should be doing so at meal time. 9-3-8(a)	W000488	Group home staff will be trained on encouraging clients to participate in meal preparation to the extent of their abilities. This training will be done through demonstration. To ensure future compliance, Service Coordinator will monitor weekly for one month and monthly thereafter.	03/27/2013

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